The University of Texas at Austin
UT Health Austin

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

I authorize the doctor or healthcare provider named below to release the medical record(s) or health information of the patient below to UT Health Austin, 1601 Trinity Street Austin, TX 78712, 1-833-UT-CARES, FAX: 512-495-5680.

Patient Information

Name: _____

Other names used:

_____

Date of birth: _____

Phone: _____

Address: _____

_____

Medical Record #:_____

Healthcare Provider Information

Name:

_____

Phone: _____

Address:

_____

_____

Dates of Treatment:

_____

_____

I ask that the following be given to UT Health Austin (select any items you want sent to UT Health Austin*):

- ❑ *All medical records*
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Billing Information
- ❑ Past/Present Medications
- ❑ Diagnostic Test Reports
- ❑ Radiology Reports & Images
- ❑ Lab Results
- ❑ EKG/Cardiology Reports
- ❑ Other: _____

*The signature of a minor patient may be required for the release of some of these items.

UNLESS YOU INITIAL HERE, no information about mental health, alcohol/substance abuse, HIV/AIDS test results, or genetic information will be disclosed. YES, PLEASE DISCLOSE:

_____Mental Health Records (excluding psychotherapy notes)*
_____Drug, Alcohol, or Substance Abuse Records
_____ HIV/AIDS Test Results/Treatment
_____Genetic Information

*Release of psychotherapy notes requires a separate Authorization

Reason for Disclosure (select one):

- ❑ Treatment/ Continuing Medical Care
- ❑ At the Request of Patient
- ❑ Other _____

This authorization will be in effect for one year or until _____ (date or event).

By signing below, I agree:

- *I may withdraw my permission at any time. If I withdraw my permission, my PHI will not be released again as set forth above. However, any disclosures already made based on this will not be affected. I may withdraw my permission by notifying the healthcare provider listed above in writing.*
- *I am not required to sign this form to receive treatment or healthcare benefits from my health plan. This Authorization is voluntary, and I may refuse to sign it. I may request a copy of this signed form.*
- *I release the healthcare provider listed above from legal responsibility or liability for the disclosure of the records as stated on this form.*
- *I have read this form and agree to the uses and disclosures of the information as described above. I understand PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the person or party it goes to and may no longer be protected by federal or state privacy laws.*

Signature of Patient or Representative: _____ ***Date:*** _____

Printed Name of Patient or Representative: _____

Relationship to Patient: _____